

Sun Life Assurance Company of Canada

Application for Group Insurance



1. Applicant Organization

Please PRINT clearly.

Full legal name (As it is to be shown in the Group Policy)		
City of Leesburg, FL		
Main office address		
501 West Meadow Street		
City	State	Zip code
Leesburg	FL	34748

Type of Organization: ☐ Corporation ☐ S Corporation ☐ Partnership
☐ Sole Proprietor ☐ LLC/LLP ☒ City

Subsidiaries or Affiliates to be Included

1.	Legal name
	Full address (street, city, state and zip code)
2.	Legal name
	Full address (street, city, state and zip code)

☐ If you need more space, check here and attach a separate page.

2. Insurance Coverage Requested

If any requested coverage is to have a different effective date than the date indicated at right, please note the effective date next to the coverage.

Requested effective date (mm/dd/yy)
10/1/2012

- | | |
|--|---|
| <input type="checkbox"/> Employee Basic Life | <input checked="" type="checkbox"/> Employee Optional Life |
| <input checked="" type="checkbox"/> Employee Basic Life and AD&D | <input checked="" type="checkbox"/> Employee Optional AD&D |
| <input type="checkbox"/> Dependent Basic Life | <input checked="" type="checkbox"/> Dependent Optional Life |
| <input type="checkbox"/> Spouse only <input type="checkbox"/> Family | <input type="checkbox"/> Spouse only <input checked="" type="checkbox"/> Family |
| <input type="checkbox"/> Dependent Basic AD&D | <input checked="" type="checkbox"/> Dependent Optional AD&D |
| <input type="checkbox"/> Spouse only <input type="checkbox"/> Family | <input checked="" type="checkbox"/> Spouse only <input type="checkbox"/> Family |
| <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Standalone Voluntary AD&D |
| <input type="checkbox"/> Short Term Disability | <input type="checkbox"/> Employee <input type="checkbox"/> Family |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Employee Voluntary Life |
| | <input type="checkbox"/> Employee Voluntary AD&D |
| | <input type="checkbox"/> Dependent Voluntary Life |
| | <input type="checkbox"/> Spouse only <input type="checkbox"/> Family |
| | <input type="checkbox"/> Dependent Voluntary AD&D |
| | <input type="checkbox"/> Spouse only <input type="checkbox"/> Family |
| | <input type="checkbox"/> Other _____ |

2. Insurance Coverage Requested continued

Premium Information

If Sun Life Assurance Company of Canada does not agree to provide the coverage requested in this Application, it will return the amount paid with the application to the Applicant. No insurance shall take effect until Sun Life Assurance Company of Canada approves this Application and issues an insurance policy to the Applicant.

Amount Paid with this Application \$

3. Fraud Warnings

Please read the fraud warning below before signing this form. Where noted, state law requires that we notify you of the following:

Fraud Warning (except as specified below): Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

Fraud Warning – CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – FL: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Fraud Warning – KY: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects that person to criminal and civil penalties.

Fraud Warning – MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – OR: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

Fraud Warning – VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Fraud Warning – VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

4. Terms of Agreement

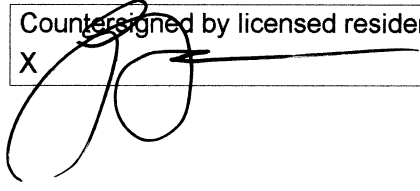
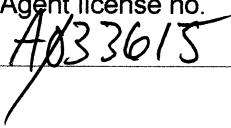
The Applicant hereby applies for Group Insurance as specified in the Sun Life Assurance Company of Canada (Sun Life) proposal. The undersigned Applicant has read, understands and agrees that:

1. The insurance requested in this Application for Group Insurance will not become effective until you have been notified in writing by Sun Life that it has been approved. As such, you should carefully consider whether you should terminate your existing group insurance coverage prior to Sun Life notifying you that it has made a determination with respect to the insurance requested in your Application for Group Insurance.
2. The requested group insurance will:
 - be issued only if the requested insurance is accepted by Sun Life and is legally permissible;
 - be issued under a Group Policy or Policies in the language customarily used by Sun Life;
 - be subject to Sun Life's standard underwriting requirements; and
 - take effect on the date determined by Sun Life.
3. All information given in connection with this Application for Group Insurance is true and complete to the best of the Applicant's knowledge, information and belief.
4. Premium rate quotes are based on the data previously submitted to Sun Life. Final premium rates will be determined based on the final census submitted. Sun Life reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete.
5. If Sun Life approves an Applicant's request for group insurance coverage, employees who are not actively at work on the group insurance policy's effective date will only be insured if they satisfy the policy's "Continuity of Coverage" provision or are required to be covered by law.
6. No producer, agent or broker can make or modify a contract for Sun Life and all coverage will be as stated in Sun Life policies. No agent or broker has the authority to guarantee the acceptability of the requested insurance.
7. When you purchase insurance from us, we pay compensation to the producer and/or to the agency through which the producer works. If the producer works through an agency, the agency may pay compensation directly to the producer. Compensation may include commissions when a policy is purchased or renewed, and fees for other services. The compensation may vary by the type of insurance purchased. Additionally, bonuses and incentive trips or awards associated with sales may be paid based on the overall sales volume or persistency of business. The compensation that we pay to producers may differ from that paid by other insurance companies. If you have questions, contact your producer directly.
8. This Application is made a part of the Group Policy.

5. Authorization

I acknowledge that I have read and understood the Terms of Agreement and the Fraud Notices above.

Name and title of Applicant organization's Authorized Representative			
Signature of Authorized Representative X			
Place of signing <i>Leesburg, FL</i>		Date	
Name of Agent/Broker L B Bryan & Company / Lon Bryan		Agent/Broker license no. A033615	
Street address 3036A Harbor Drive	City St. Augustine	State FL	Zip code 32084
Signature of Agent/Broker X <i>[Signature]</i>		Date 8-16-2012	

Countersigned by licensed resident agent (where required by law) X 	Agent license no.  A033615
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